FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040444

Facility Name: SHERIDAN SHORES CARE

Address: 5838 NORTH SHERIDAN (Number) CHICAGO (City) 60660 (Zip Code)

County: COOK

Telephone Number: (773) 769-2230 **Fax #** (773) 769-3579

IDPA ID Number: 363873049001

Date of Initial License for Current Owners: 06/04/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) Edward Slack, CPA
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	127	Skilled (SNF)	127	46,355	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,265	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,303	478	1,708	15,489	8
9	SNF/PED					9
10	ICF	47,087	1,114		48,201	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,390	1,592	1,708	63,690	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.82%

D. How many bed-hold days during this year were paid by Public Aid?
733 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 1,347

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	200,588	21,582	9,613	231,783		231,783	(6,586)	225,197			1
2	Food Purchase		228,424		228,424	(26,317)	202,108	4,032	206,139			2
3	Housekeeping	157,168	38,074		195,242		195,242	(902)	194,340			3
4	Laundry	70,104	17,979		88,083		88,083		88,083			4
5	Heat and Other Utilities			173,078	173,078		173,078	1,649	174,727			5
6	Maintenance	89,886		122,092	211,978		211,978	5,142	217,120			6
7	Other (specify):*							1,306	1,306			7
8	**TOTAL General Services**	517,746	306,059	304,783	1,128,588	(26,317)	1,102,272	4,641	1,106,912			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,949,886	53,459	19,382	2,022,727		2,022,727	8,049	2,030,776			10
10a	Therapy	47,117	4,537	8,736	60,390		60,390		60,390			10a
11	Activities	117,263	9,712	2,268	129,243		129,243	2	129,245			11
12	Social Services	205,588	713	1,712	208,013		208,013	14	208,027			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							1,628	1,628			15
16	**TOTAL Health Care and Programs**	2,319,854	68,421	36,898	2,425,173		2,425,173	9,693	2,434,866			16
	C. General Administration											
17	Administrative	101,283		48,000	149,283		149,283	33,556	182,839			17
18	Directors Fees											18
19	Professional Services			133,171	133,171		133,171	(71,257)	61,914			19
20	Dues, Fees, Subscriptions & Promotions			44,583	44,583		44,583	(6,610)	37,973			20
21	Clerical & General Office Expenses	72,435	25,568	345,267	443,270		443,270	(198,071)	245,199			21
22	Employee Benefits & Payroll Taxes			528,781	528,781	26,317	555,098		555,098			22
23	Inservice Training & Education			2,779	2,779		2,779		2,779			23
24	Travel and Seminar			2,820	2,820		2,820	1,260	4,080			24
25	Other Admin. Staff Transportation			1,461	1,461		1,461		1,461			25
26	Insurance-Prop.Liab.Malpractice			236,596	236,596		236,596	1,160	237,756			26
27	Other (specify):*							17,936	17,936			27
28	**TOTAL General Administration**	173,718	25,568	1,343,458	1,542,744	26,317	1,569,061	(222,026)	1,347,035			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,011,318	400,048	1,685,139	5,096,505		5,096,505	(207,692)	4,888,813			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SHERIDAN SHORES CARE #0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			107,805	107,805		107,805	(1,127)	106,678			30
31	Amortization of Pre-Op. & Org.			3,228	3,228		3,228	9,759	12,987			31
32	Interest			162,257	162,257		162,257	11,719	173,976			32
33	Real Estate Taxes			235,435	235,435		235,435	2,861	238,296			33
34	Rent-Facility & Grounds			1,036,337	1,036,337		1,036,337	38	1,036,375			34
35	Rent-Equipment & Vehicles			4,645	4,645		4,645	3,223	7,868			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,549,707	1,549,707		1,549,707	26,473	1,576,180			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,722	90,581	187,303		187,303	(1,009)	186,294			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		96,722	193,511	290,233		290,233	(1,009)	289,224			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,011,318	496,770	3,428,357	6,936,445		6,936,445	(182,228)	6,754,217			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(4,390)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,492)	30		9
10	Interest and Other Investment Income	(72)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(56)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(304,896)	21		24
25	Fund Raising, Advertising and Promotional	(3,471)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(183)	20		28
29	Other-Attach Schedule	(14,015)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (339,575)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	157,347		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 157,347		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (182,228)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

SHERIDAN SHORES CARE

ID# 0040444

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	COPE	(2,748)	20	2
3	Misc. Private Revenue	(12)	10	3
4	Jury Duty Income	(17)	10	4
5	Collection Expense	(127)	21	5
6	Bank Charges	(3,246)	21	6
7	Theft Loss	(95)	21	7
8	Enteral Expense (PPA)	(230)	39	8
9	Trust Fund Fee	(108)	21	9
10	Fine	(1,500)	20	10
11	Prior Year Legal Fees	(5,602)	19	11
12	Late Fee	(330)	22	12
13				13
14				14
15				15
16				16
17				17
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98				98
99				99
100				100
101	Total	(14,015)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					5,024	(6,196)	(5,414)					(6,586)	1
2	Food Purchase	(56)		(142)			4,230						4,032	2
3	Housekeeping							(902)					(902)	3
4	Laundry													4
5	Heat and Other Utilities			1,649									1,649	5
6	Maintenance			3,225		1,908	9						5,142	6
7	Other (specify):*					937	369						1,306	7
8	**TOTAL General Services**	(56)		4,732		7,869	(1,588)	(6,316)					4,641	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(29)		(39)		11,821	5	(3,709)					8,049	10
10a	Therapy													10a
11	Activities			2									2	11
12	Social Services					14							14	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*					1,628							1,628	15
16	**TOTAL Health Care and Programs**	(29)		(37)		13,463	5	(3,709)					9,693	16
	C. General Administration													
17	Administrative			388		33,023	145						33,556	17
18	Directors Fees													18
19	Professional Services	(5,602)		(65,945)			290						(71,257)	19
20	Fees, Subscriptions & Promotions	(7,902)		1,276			16						(6,610)	20
21	Clerical & General Office Expenses	(308,472)		15,903		94,290	208						(198,071)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			949			311						1,260	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,160									1,160	26
27	Other (specify):*					17,936							17,936	27
28	**TOTAL General Administration**	(321,976)		(46,269)		145,249	970						(222,026)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(322,061)		(41,574)		166,581	(613)	(10,025)					(207,692)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(12,492)		11,365									(1,127)	30
31	Amortization of Pre-Op. & Org.		9,759										9,759	31
32	Interest	(402)		12,121									11,719	32
33	Real Estate Taxes			2,861									2,861	33
34	Rent-Facility & Grounds	(4,390)		4,420			8						38	34
35	Rent-Equipment & Vehicles			3,211			12						3,223	35
36	Other (specify):*													36
37	TOTAL Ownership	(17,284)	9,759	33,978			20						26,473	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(230)					(779)						(1,009)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(230)					(779)						(1,009)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(339,575)	9,759	(7,596)		166,581	(1,372)	(10,025)					(182,228)	45

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Edgewater Care & Rehab Center Bldg, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income / Expense	$ 1,036,337	Edgewater Care & Rehab Center Building, LLC	100.00%	$ 1,036,337	$	1
2	V	33	Rental Income / Exp - RE Tax	235,435	Edgewater Care & Rehab Center Building, LLC	100.00%	235,435		2
3	V	31	Amortization Expense		Edgewater Care & Rehab Center Building, LLC	100.00%	9,759	9,759	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,271,772			$ 1,281,531	$ * 9,759	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	$	Care Centers, Inc.	100.00%	$ 1,649	$ 1,649	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	3,225	3,225	16
17	V	10	Nursing	47	Care Centers, Inc.	100.00%	8	(39)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	2	2	18
19	V	19	Professional Fees	75,550	Care Centers, Inc.	100.00%	9,605	(65,945)	19
20	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	1,276	1,276	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	15,903	15,903	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	949	949	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	1,160	1,160	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	11,365	11,365	24
25	V	32	Interest		Care Centers, Inc.	100.00%	12,121	12,121	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,861	2,861	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	4,420	4,420	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	3,211	3,211	28
29	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			29
30	V	02	Food	142	Care Centers, Inc.	100.00%		(142)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	388	388	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 75,739			$ 68,143	$ * (7,596)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	$	Care Centers, Inc.	100.00%	$	$	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%			17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%			18
19	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			19
20	V	11	Activity Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Service Salary		Care Centers, Inc.	100.00%			21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%			22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%			23
24	V	21	Office Salary		Care Centers, Inc.	100.00%			24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%			25
26	V	22	Employee Benefits		Care Centers, Inc.	100.00%			26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Care Centers, Inc.	100.00%	$ 5,024	$ 5,024	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	1,908	1,908	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	937	937	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	11,821	11,821	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	14	14	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,628	1,628	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	33,023	33,023	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	94,290	94,290	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	17,936	17,936	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 166,581	$ * 166,581	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 10,089	Care Centers, Inc. - Health Systems Division	100.00%	$ 1,147	$ (8,942)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	4,230	4,230	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	9	9	17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%	5	5	18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	145	145	19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	290	290	20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	16	16	21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	208	208	22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	311	311	23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	8	8	24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	12	12	25
26	V	39	Ancillary Enteral Supplies	2,324	Care Centers, Inc. - Health Systems Division	100.00%	1,545	(779)	26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,746	2,746	27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	369	369	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,413			$ 11,041	$ * (1,372)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 39,960	XCEL Medical Supply, LLC	100.00%	$ 34,546	$ (5,414)	15
16	V	03	Housekeeping	6,660	XCEL Medical Supply, LLC	100.00%	5,758	(902)	16
17	V	10	Nursing	27,380	XCEL Medical Supply, LLC	100.00%	23,671	(3,709)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,000			$ 63,975	$ * (10,025)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 99,147	$ 99,147	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	99,147				(99,147)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 99,147			$ 99,147	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	3.19%	see attached	1.9	2.64%	Mgmt Fee	$ 24,000	17-3	1
2	Norm Goldberg	Owner	Administrative	2.13%	see attached	1.94	3.88%	CCI salary	4,047	17-7	2
3	Mark Steinberg	Relative	Administrative		see attached	1.94	3.88%	CCI salary	1,757	17-7	3
4	Melissa Rothner	Relative	Clerical		see attached			CCI salary	39	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 29,843		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	1,640,756	39	$ 42,470	$	63,690	$ 1,649	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080		63,690	3,225	2
3	10	Nursing	Patient Days	1,640,756	39	205		63,690	8	3
4	11	Activities	Patient Days	1,640,756	39	51		63,690	2	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437		63,690	9,605	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863		63,690	1,276	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698		63,690	15,903	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743		63,690	949	8
9	26	Insurance	Patient Days	1,640,756	39	29,875		63,690	1,160	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776		63,690	11,365	10
11	32	Interest	Patient Days	1,640,756	39	312,254		63,690	12,121	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702		63,690	2,861	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857		63,690	4,420	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710		63,690	3,211	14
15	17	Administration	Patient Days	1,640,756	39	10,000		63,690	388	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,721	$		$ 68,143	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping Salary	Direct Cost			45,667	45,667			1
2	06	Maintenance Salary	Direct Cost			169,934	169,934			2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost			29,646				3
4	10	Nursing Salary	Direct Cost			895,582	895,582			4
5	10a	Rehab Salary	Direct Cost			128,376	128,376			5
6	11	Activity Salary	Direct Cost			57,201	57,201			6
7	12	Social Service Salary	Direct Cost			63,966	63,966			7
8	15	Emp. Ben. - Healthcare	Direct Cost			157,159				8
9	17	Administration Salary	Direct Cost			1,334,207	1,334,207			9
10	21	Office Salary	Direct Cost			740,101	740,101			10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost			290,105				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,911,943	$ 3,435,033		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,640,756	39	129,417	129,417	63,690	5,024	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	49,148	63,690	1,908	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132		63,690	937	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	304,530	63,690	11,821	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	354	63,690	14	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952		63,690	1,628	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	850,731	63,690	33,023	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	2,429,052	63,690	94,290	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069		63,690	17,936	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,291,386	$ 3,763,233		$ 166,581	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,191,458		182,448		13,775	1,147	1
2	02	Food	Billable Income	2,191,458		834,365		13,775	4,230	2
3	06	Maintenance	Billable Income	2,191,458		1,400		13,775	9	3
4	10	Nursing	Billable Income	2,191,458		850		13,775	5	4
5	17	Administration	Billable Income	2,191,458		23,000		13,775	145	5
6	19	Professional Fees	Billable Income	2,191,458		46,205		13,775	290	6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514		13,775	16	7
8	21	Office & Clerical	Billable Income	2,191,458		33,124		13,775	208	8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456		13,775	311	9
10	34	Rent - Building	Billable Income	2,191,458		1,300		13,775	8	10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830		13,775	12	11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436		13,775	1,545	12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887	13,775	2,746	13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714		13,775	369	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,756,530	$ 436,887		$ 11,041	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Xcel Medical Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847) 328-7600
Fax Number: (847) 328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$ 34,546	1
2	03	Housekeeping	Direct Allocation						5,758	2
3	10	Nursing	Direct Allocation						23,671	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 63,975	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 99,147	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 99,147	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Hunter Management	X		Working Capital			160,000	135,261			9,141	6
7	Diawa	X		Line of Credit				2,700,943			142,911	7
8	Cananville Inc		X	Insurance Financing							8,139	8
9	TOTAL Facility Related						$ 160,000	$ 2,836,204			$ 160,191	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							75,000			17,618	10
11												11
12	Compass Financial		X								168	12
13	Prior Period Adjustment										(4,000)	13
14	TOTAL Non-Facility Related						$	$ 75,000			$ 13,786	14
15	TOTALS (line 9+line14)						$ 160,000	$ 2,911,204			$ 173,977	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2	Interest Income										(72)	2
3	Allocation from Care Centers	X									12,121	3
4	Shareholders Loan	X						75,000			5,569	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 75,000			$ 17,618	21

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	272,655	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	250,710	2
3. Under or (over) accrual (line 2 minus line 1).	$	(21,945)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	260,241	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	238,296	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	285,880	8
1998	286,694	9
1999	284,769	10
2000	241,566	11
2001	247,849	12

2002 accrual = 2001 tax + 5% ($247,849 x 105% = $260,241)

Allocation from Care Centers $2861

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHERIDAN SHORES CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-402-027-0000	LONG TERM CARE PROPERTY	$ 123,924.50	$ 123,924.50
2.	14-05-402-028-0000	LONG TERM CARE PROPERTY	$ 123,924.50	$ 123,924.50
3.	SEE ATTACHED	HOME OFFICE ALLOCATION	$ 70,261.69	$ 2,727.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 318,110.69	$ 250,576.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHERIDAN SHORES CARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 90,329
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 12,987
4. Dates Incurred: Various

Nature of Costs: Financing Fees, Assignment Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	Allocation Care Centers			16,327	2
3	TOTALS			$ 16,327	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	42,874		20	2,145	2,145	20,023	9
10	Various			1994	57,552		20	2,878	2,878	24,689	10
11	Various			1995	146,433		20	7,322	7,322	56,044	11
12	Various			1996	67,704		20	3,385	3,385	22,323	12
13	Various			1997	53,902		20	2,696	2,696	14,957	13
14	Various			1998	172,679		20	8,637	8,637	39,693	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		43,331	1,807		1,854	47	149	68
69	Financial Statement Depreciation			28,770			(28,770)		69
70	TOTAL (lines 4 thru 69)		$ 584,475	$ 30,577		$ 28,917	$ (1,660)	$ 177,878	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 584,475	$ 30,577		$ 28,917	$ (1,660)	$ 177,878	1
2	LIFE SAFETY	1999	4,500		20	225	225	900	2
3	PHONE RENOV	1999	861		20	43	43	168	3
4	HEATER RENOV	1999	1,080		20	54	54	212	4
5	MIXER RENOV	1999	824		20	41	41	161	5
6	SMOKE DAMPER	1999	789		20	39	39	153	6
7	OXYGEN EXHAUST	1999	5,677		20	284	284	1,112	7
8	SPRINKLER SYSTEM	1999	3,240		20	162	162	635	8
9	DOOR/HINGES	1999	1,445		20	72	72	276	9
10	CARPET	1999	589		20	29	29	111	10
11	PAINT	1999	592		20	30	30	115	11
12	CUBICLE CURTAINS	1999	845		20	42	42	158	12
13	HEATER RENOV	1999	1,903		20	95	95	348	13
14	COMPRESSOR	1999	1,209		20	60	60	220	14
15	GENERATOR RENOV	1999	535		20	27	27	90	15
16	ELEVATOR RENOV	1999	3,301		20	165	165	536	16
17	TV WIRING	1999	6,500		20	325	325	1,029	17
18	PAVEMENT IMPROV	1999	1,990		20	100	100	350	18
19	PAVEMENT IMPROV	1999	3,980		20	199	199	697	19
20	TUCKPOINTING	1999	2,200		20	110	110	385	20
21	A/C RENOV	1999	573		20	29	29	102	21
22	CEILING TILE	1999	703		20	35	35	120	22
23	CEILING TILE	1999	703		20	35	35	120	23
24	COVE BASE	1999	2,156		20	108	108	387	24
25	LANDSCAPING	1999	1,000		20	50	50	179	25
26	BOILER RENOV	1999	741		20	37	37	133	26
27	KEYSWITCH	1999	865		20	43	43	154	27
28	CEILING TILE	1999	536		20	27	27	90	28
29	DOORS	1999	2,895		20	145	145	483	29
30	GENERATOR RENOV	1999	964		20	48	48	160	30
31	GENERATOR RENOV	1999	1,176		20	59	59	197	31
32	WOOD DOORS	1999	2,350		20	118	118	403	32
33	WIRING	1999	945		20	47	47	161	33
34	TOTAL (lines 1 thru 33)		$ 642,142	$ 30,577		$ 31,800	$ 1,223	$ 188,223	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 642,142	$ 30,577		$ 31,800	$ 1,223	$ 188,223	1
2	GENERATOR RENOV	1999	545		20	27	27	81	2
3	TRANSMITTER	1999	732		20	37	37	111	3
4	BOILER RENOV	1999	702		20	35	35	111	4
5	TILE	1999	542		20	27	27	97	5
6	A/C RENOV	1999	1,351		20	68	68	244	6
7	REFRIG RENOV	1999	1,143		20	57	57	171	7
8	PAINT	2000	3,760		20	188	188	564	8
9	TV WIRING	2000	7,384		20	369	369	1,107	9
10	PAINT	2000	2,956		20	148	148	419	10
11	CORNERS GUARDS	2000	2,933		20	147	147	417	11
12	FYRE-SHIELD	2000	987		20	49	49	139	12
13	WALLPAPER	2000	22,360		20	1,118	1,118	3,075	13
14	CORNER GUARDS	2000	3,618		20	181	181	498	14
15	PAINT	2000	759		20	38	38	101	15
16	PAINT	2000	(111)		20	(6)	(6)	(16)	16
17	PAINT	2000	621		20	31	31	83	17
18	PAINT	2000	301		20	15	15	40	18
19	ELECTRICAL	2000	2,170		20	109	109	291	19
20	SECO REFRIGERATION	2000	1,572		20	79	79	204	20
21	PAINT	2000	700		20	35	35	90	21
22	WIRING	2000	1,225		20	61	61	153	22
23	LIFT HANDLES	2000	1,503		20	75	75	188	23
24	RADIATOR	2000	8,963		20	448	448	1,120	24
25	WIRING	2000	725		20	36	36	87	25
26	WIRING	2000	500		20	25	25	60	26
27	AWNING	2000	6,970		20	349	349	843	27
28	CAMERA SYSTEM	2000	2,274		20	114	114	266	28
29	HVAC	2000	525		20	53	53	119	29
30	RADIATOR	2000	11,823		20	591	591	1,281	30
31	REFRIG RENOV	2000	2,254		20	113	113	330	31
32	REFRIG RENOV	2000	4,180		20	209	209	592	32
33	COVE BASE	2000	3,200		20	160	160	440	33
34	TOTAL (lines 1 thru 33)		$ 741,309	$ 30,577		$ 36,786	$ 6,209	$ 201,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 741,309	$ 30,577		$ 36,786	$ 6,209	$ 201,529	1
2	HANDRAILS	2000	3,911		20	196	196	523	2
3	COVE BASE	2000	854		20	43	43	115	3
4	PAINT	2000	1,954		20	98	98	245	4
5	PAINT	2000	969		20	48	48	116	5
6	WALL GUARD	2000	1,840		20	92	92	222	6
7	DRYWALL	2000	1,200		20	60	60	140	7
8	DOOR HOLDERS	2000	19,985		20	999	999	2,248	8
9	WINDOW TREATMENTS	2000	5,587		20	279	279	628	9
10	BLOWER WHEELS	2000	1,045		20	52	52	113	10
11	BLOW OFF VALVE	2000	1,001		20	50	50	108	11
12	MIXING VALVE	2000	3,369		20	168	168	364	12
13	TRANSMITTER	2000	924		20	46	46	100	13
14	MOTOR	2000	609		20	30	30	73	14
15	CUBICLES	2000	10,155		20	508	508	1,185	15
16	HATCH SILL	2000	1,970		20	99	99	223	16
17	EXPANSION TANK	2001	572		20	29	29	58	17
18	PIPE INSULATION	2001	956		20	48	48	96	18
19	PILOT ASSEMBLY	2001	518		20	26	26	52	19
20	MOTOR	2001	1,135		20	57	57	114	20
21	MOTOR	2001	1,386		20	69	69	132	21
22	TRANSMITTER	2001	924		20	46	46	88	22
23	WIRING	2001	1,274		20	64	64	123	23
24	GENERATOR	2001	589		20	29	29	56	24
25	PAINT	2001	924		20	46	46	81	25
26	CUBICLE CURTAINS	2001	17,136		20	857	857	1,643	26
27	ELEVATOR	2001	1,522		20	76	76	133	27
28	AIR CONDITIONING	2001	1,294		20	65	65	108	28
29	COMPRESSOR	2001	1,218		20	61	61	97	29
30	SEWER LINES	2001	3,692		20	185	185	293	30
31	WINDOW COVERINGS	2001	2,328		20	116	116	174	31
32	DOMESTIC WATER PIPIN	2001	548		20	27	27	38	32
33	WIRING	2001	1,140		20	57	57	114	33
34	TOTAL (lines 1 thru 33)		$ 833,838	$ 30,577		$ 41,412	$ 10,835	$ 211,332	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 833,838	$ 30,577		$ 41,412	$ 10,835	$ 211,332	1
2	TRANSMITTER	2001	924		20	46	46	92	2
3	STEEL DOOR	2001	1,199		20	60	60	85	3
4	WIRING	2001	4,785		20	239	239	478	4
5	DRYWALL	2001	638		20	32	32	64	5
6	FLAME CONTROL CENTER	2001	1,402		20	70	70	123	6
7	CUBICLE CURTAINS	2001	693		20	35	35	58	7
8	FIRE ALARM	2001	800		20	40	40	67	8
9	TRANSMITTER	2001	940		20	47	47	78	9
10	FLOW SWITCH	2001	765		20	38	38	63	10
11	STEEL SHUTES, DOOR	2001	1,332		20	67	67	101	11
12	EXHAUST SYSTEM	2001	543		20	27	27	38	12
13	FEDDERS	2001	5,285		20	264	264	374	13
14	TOILET R & M	2002	747		20	75	75	75	14
15	CEILING FANS	2002	700		20	70	70	70	15
16	DOORS	2002	1,199		20	60	60	60	16
17	DEPOSIT ON DON OFFICE REMODELING	2002	1,859		20	186	186	186	17
18	WATER PUMP LEAKING	2002	2,449		20	245	245	245	18
19	ROOF MAINTENANCE	2002	3,800		20	380	380	380	19
20	ELECTRIC WIRING	2002	615		20	62	62	62	20
21	NEW WATER PRESSURE VALVE	2002	656		20	131	131	131	21
22	NURSE CALL SYSTEM	2002	2,100		20	140	140	140	22
23	TILE OUTLET-TILES	2002	990		20	61	61	61	23
24	ELEVATOR REPAIR	2002	1,110		20	46	46	46	24
25	PLUMBING REPAIR	2002	565		20	47	47	47	25
26	BOILER REPAIR	2002	594		20	37	37	37	26
27	COOLING TOWER REPAIR	2002	541		20	41	41	41	27
28	A/C REPAIR	2002	852		20	53	53	53	28
29	POWER TRON REPAIR	2002	1,791		20	134	134	134	29
30	COUNTERTOPS	2002	2,300		20	173	173	173	30
31	PLUMBING REPAIR	2002	690		20	46	46	46	31
32	BOILER REPAIR	2002	1,334		20	74	74	74	32
33	DOORS	2002	1,050		20	35	35	35	33
34	TOTAL (lines 1 thru 33)		$ 879,086	$ 30,577		$ 44,473	$ 13,896	$ 215,049	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 879,086	$ 30,577		$ 44,473	$ 13,896	$ 215,049	1
2	SUMP PUMP R & M	2002	2,214		20	129	129	129	2
3	PLUMBING REPAIR	2002	824		20	48	48	48	3
4	PLUMBING REPAIR	2002	2,940		20	172	172	172	4
5	ANTENNAS	2002	1,065		20	124	124	124	5
6	DOOR	2002	635		20	19	19	19	6
7	HVAC FEEDERS	2002	5,252		20	255	255	255	7
8	FREEZER R&M	2002	1,848		20	132	132	132	8
9	HVAC R&M	2002	599		20	30	30	30	9
10	ANTENNAS	2002	1,065		20	107	107	107	10
11	TIMECLOCK INSTALLATION	2002	759		20	63	63	63	11
12	CEILING TILE	2002	758		20	13	13	13	12
13	POWERTRON REPAIR	2002	777		20	45	45	45	13
14	BOOSTER CIRCUIT FOR WATER BOOSTER	2002	516		20	39	39	39	14
15	BATHROOM REMODELING	2002	3,276		20	300	300	300	15
16	ROOF	2002	1,050		20	26	26	26	16
17	VERTICAL BLINDS	2002	2,034		20	51	51	51	17
18	BOILER	2002	1,876		20	47	47	47	18
19	DRYWALL	2002	850		20	21	21	21	19
20	ELECTRIC	2002	826		20	41	41	41	20
21	HOT WATER HEATER	2002	11,675		20	1,070	1,070	1,070	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	1
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	1
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3									3
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	1
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	1
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	1
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 919,925	$ 30,577		$ 47,205	$ 16,628	$ 217,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5	CCI		1996			1,033	35	1,151	118		5
6	CCI		2002		22,499	42	35	62	20	62	6
7											7
8											8
	Improvement Type**										
9	Care Centers allocation			2002		383	20	26	(357)		9
10	Care Centers allocation			2001		1	20	6	5		10
11	Care Centers allocation			2000		1	20	2	1		11
12	Care Centers allocation			1999		19	20	36	(17)		12
13	Care Centers allocation			1998		8	20	15	7		13
14	Care Centers allocation			1997		74	20	149	75		14
15	Care Centers allocation			1996		193	20	295	102		15
16	Care Centers allocation			1997		1	20	25	24		16
17	Care Centers allocation			1994		9	20		(9)		17
18	Care Centers allocation			1993		4	20		(4)		18
19	Care Centers allocation			2002	20,832	39	20	87	48	87	19
20											20
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31											31
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34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
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68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 43,331	$ 1,807		$ 1,854	$ 13	$ 149	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 521,712	$ 82,751	$ 52,147	$ (30,604)	10	$ 252,535	71
72	Current Year Purchases	29,689	1,443	3,515	2,072	10	3,515	72
73	Fully Depreciated Assets	6,250				10	6,250	73
74								74
75	TOTALS	$ 557,651	$ 84,194	$ 55,662	$ (28,532)		$ 262,300	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Care Centers allocation		$ 26,150	$ 4,399	$ 3,811	$ (588)	5	$ 14,300	76
77										77
78										78
79										79
80	TOTALS			$ 26,150	$ 4,399	$ 3,811	$ (588)		$ 14,300	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,520,053	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 119,170	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 106,678	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,492)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 494,381	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Sam and David Gorenstein

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	Edgewater LLC			$ 1,036,337			3
4	Additions							4
5	Less: Rental Income				(4,390)			5
6	Allocation from Care Center				4,428			6
7	TOTAL				$ 1,036,375 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 7,868 Description: see attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 47,545	$		$ 47,545	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,659			2,659	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			40,377			40,377	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				53,336		53,336	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						43,386		43,386	13
14	TOTAL			$		$ 90,581	$ 96,722		$ 187,303	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 11,847	$ 11,860	1
2	Cash-Patient Deposits	68,807	68,807	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,055,327	1,055,327	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	140,934	140,934	6
7	Other Prepaid Expenses	10,313	10,313	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	322,861	371,579	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,610,089	$ 1,658,820	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	791,160	791,160	15
16	Equipment, at Historical Cost	610,475	610,475	16
17	Accumulated Depreciation (book methods)	(580,533)	(580,533)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		63,437	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	478,846	478,846	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,299,948	$ 1,363,385	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,910,037	$ 3,022,205	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 421,334	$ 421,334	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	63,028	63,028	28
29	Short-Term Notes Payable	2,911,204	2,911,204	29
30	Accrued Salaries Payable	114,065	114,065	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,836	11,836	31
32	Accrued Real Estate Taxes(Sch.IX-B)	260,241	260,241	32
33	Accrued Interest Payable	123,254	123,254	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	585,000	1,036,200	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,489,962	$ 4,941,162	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,489,962	$ 4,941,162	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,579,925)	$ (1,918,957)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,910,037	$ 3,022,205	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,124,713)	1	
2	Restatements (describe):		2	
3	**Bonus Rent**	940,000	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,184,713)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(395,212)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (395,212)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,579,925)	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,426,852	1
2	Discounts and Allowances for all Levels	(358,593)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,068,259	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	379,762	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 379,762	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,390	16
17	Sale of Drugs	52,955	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,388	19
20	Radiology and X-Ray	1,650	20
21	Other Medical Services	27,728	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 93,111	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	72	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 72	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	29	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 29	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,541,233	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,128,588	31
32	Health Care	2,425,173	32
33	General Administration	1,542,744	33
	B. Capital Expense		
34	Ownership	1,549,707	34
	C. Ancillary Expense		
35	Special Cost Centers	187,303	35
36	Provider Participation Fee	102,930	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,936,445	40
41	**Income before Income Taxes (line 30 minus line 40)****	(395,212)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (395,212)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,992	2,272	$ 65,278	$ 28.73	1
2	Assistant Director of Nursing	2,068	2,223	50,515	22.72	2
3	Registered Nurses	12,997	14,785	341,892	23.12	3
4	Licensed Practical Nurses	29,985	34,291	624,624	18.22	4
5	Nurse Aides & Orderlies	87,453	96,553	839,604	8.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,919	4,430	47,117	10.64	8
9	Activity Director	2,048	2,288	37,109	16.22	9
10	Activity Assistants	10,976	11,820	80,154	6.78	10
11	Social Service Workers	14,033	15,745	205,588	13.06	11
12	Dietician					12
13	Food Service Supervisor	2,146	2,362	30,734	13.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,430	22,524	169,854	7.54	15
16	Dishwashers					16
17	Maintenance Workers	8,872	9,820	89,886	9.15	17
18	Housekeepers	21,878	23,869	157,168	6.58	18
19	Laundry	7,789	8,332	70,104	8.41	19
20	Administrator	2,096	2,424	81,447	33.60	20
21	Assistant Administrator	2,128	2,408	19,836	8.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,363	7,010	72,435	10.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,970	2,274	27,973	12.30	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	239,143	265,430	$ 3,011,318 *	$ 11.35	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	233	$ 9,613	01-03	35
36	Medical Director	monthly	4,800	09-03	36
37	Medical Records Consultant	monthly	4,128	10-03	37
38	Nurse Consultant	43	3,857	10-03	38
39	Pharmacist Consultant	monthly	1,800	10-03	39
40	Physical Therapy Consultant	80	4,335	10a-03	40
41	Occupational Therapy Consultant	82	4,401	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,268	11-03	44
45	Social Service Consultant	31	1,712	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	516	$ 36,914		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	242	9,597	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	242	$ 9,597		53

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Todd Tedrow	Administrator		$ 81,447
Nathan Langsner	Asst Admin		19,836
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 101,283

B. Administrative - Other

Description	Amount
Nathan Langsner - Management Fee	$ 24,000
Eric Rothner - Management Fee	24,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 48,000

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 26,982
Crowe Chizek	Accounting	412
American Express & Tax	Accounting	118
Personnel Planners	Unemployment Consult	1,414
National Hot Line	Compliance Phone Service	139
TEG Services	Utility Management Service	225
Maxxsource	Computer Support	1,500
IIT / Sourcetech	Computer Support	825
Automall of America	Computer Support	80
Alpha Data	Payroll	4,326
see attached	Legal	21,600
Care Centers Inc	Various - see attached	75,550
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 133,171

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,048
Unemployment Compensation Insurance	36,721
FICA Taxes	225,853
Employee Health Insurance	138,035
Employee Meals	26,317
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	10,404
Pension Expense	29,242
Misc Employee Welfare	4,478
TOTAL (agree to Schedule V, line 22, col.8)	$ 555,098

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	24,417
Health Care Worker Background Check	2,466
(Indicate # of checks performed 227)	
Advertising & Promotion	3,471
Yellow Page Advertising	183
Dues & Subscriptions	8,125
Licenses & Fees	1,473
Allocation from Care Centers	1,276
Allocation from CCI Health Systems	16
Less: Public Relations Expense	( )
Non-allowable advertising	(3,471)
Yellow page advertising	(183)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,973

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,820
Allocation from Care Center	949
Allocation from CCI Health Systems	311
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,080

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHERIDAN SHORES CARE # 0040444 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $9001**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,610** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **102,930**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **26,317** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees